

GNA ED CENTER

SAP TEAM

STUDENT ASSISTANCE PROGRAM

REQUEST FOR PARENT/GUARDIAN INFORMATION

Parent/Guardians play a vital role in the Student Assistance process. As the prime caregiver of a child, you are in a position to see and hear many things we may not witness in school. The purpose of this form is to provide us with that information, so we may better serve you and your child.

Parent/Guardian Name _____

Student Name _____

1. What does your child tell you about his/her school experiences?
2. Do you feel your child is experiencing any difficulties? (If "no" then skip to question 3; if "yes" what do you think those difficulties are, and what do you feel is causing them?)
3. Do you think there is anything the school can do to better help your child? (Obviously some things are beyond the school of the school, but we can recommend outside resources if needed)

* If there is anything else you would like to add please utilize the back of this page

GNA ED CENTER

SAP TEAM

STUDENT ASSISTANCE PROGRAM

PARENT PERMISSION FORM

Date: _____

I give permission for my son/daughter;

To participate in the Student Assistance Program (SAP) of the GNA Educational Center as it was explained to me by:

(Name)

I permit the Student Assistance Team to release relevant information for my child's records (ex. Educational, behavioral, counseling records, psychiatric or psychological evaluations, intake/discharge summaries, drug and alcohol treatment summaries) for the purpose of a Student Assistance assessment. All Student Assistance information will be maintained in the strictest confidence.

(Signature)

(Date)

-----OR-----

The Student Assistance Team has offered me services for my child which I have refused at this time. I understand I may change my mind at any time.

(Signature)

(Date)

(Signature of Case Manager)

(Date)

* Your immediate response is appreciated

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SAP TEAM

STUDENT ASSISTANCE PROGRAM

PARENT PERMISSION FORM FOR AGENCY

Date: _____

I give permission for my son/daughter;

To participate with the following agency(s)

(Name)

I permit the Student Assistance Team to release relevant information for my child's records (ex. Educational, behavioral, counseling records, psychiatric or psychological evaluations, intake/discharge summaries, drug and alcohol treatment summaries) for the purpose of a Student Assistance assessment. All Student Assistance information will be maintained in the strictest confidence.

(Signature)

(Date)

-----OR-----

The Student Assistance Team has offered me services for my child which I have refused at this time. I understand I may change my mind at any time.

(Signature)

(Date)

(Signature of Case Manager)

(Date)

* Your immediate response is appreciated

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SAP TEAM

STUDENT ASSISTANCE PROGRAM

PEER REFERRAL FORM

CONFIDENTIAL

Name of student being referred _____

Reason for referral (Circle one or more appropriate concerns)

Social or Behavior concerns

Family problems

Changes in personality

Academic problems

Depression or extreme sadness

Drug use

Suicide concern

Alcohol use

Sexual or health concerns

Tobacco use

Other _____

Would you like to add any other information?

Your name (optional) _____